

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048632

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 19313950

SL-15875

1003

12340

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b 3 Days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 210 East Main		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BELL Middle (ODOM) Last ODUM		4. DATE OF DEATH Month DECEMBER Day 22 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-22-93
9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (City and state or country) DOVER TENN.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN ODUM		13b. MOTHER'S MAIDEN NAME GEORGIA HARRIS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) YES (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO.		17. NEAREST RELATIVE (Name and Address) Gerline (Cousin) 4007 PONTOON ILLINOIS	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHO PNEUMONIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MASSIVE G. I. HEMORRHAGE (2) DUODENAL ULCER		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 9:10 PM Month, Day, Year 12-19-62		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. John	
21. attended the deceased from 12-19-62 to 12-22-62 and last saw him alive on 12-22-62 Death occurred at 9:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Albert P. Kovac (Degree or title) M.D.	
22b. ADDRESS VAH, ST. LOUIS, MISSOURI		22c. DATE SIGNED 12/22/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/26/62	23c. NAME OF CEMETERY OR CREMATORY St. John	
23d. LOCATION (City, town, or county) Collinsville, Illinois		25. DATE RECD. BY LOCAL REG. DEC 24 1962	
26. REGISTRAR'S SIGNATURE Carl Smith. M.D.		27. FUNERAL DIRECTOR Collinsville, Ill.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Herbert H. Kuty

Licensed Embalmer No. 2803

P. O. Address Collinsville, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.